3 Hospital Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by hospital facilities as deemed appropriate by Medicaid. It addresses the following:

- Electronic and paper claims billing
- Claims payment
- Prior authorization
- Inpatient policy
- Outpatient policy
- Administratively Necessary Days (AND)
- Exclusions
- Accommodation revenue codes
- Ancillary revenue codes
- ASC surgical procedures
- Hospital owned and operated ambulance services

3.1.2 Swing Beds

For those hospitals that meet the Code of Federal Regulation requirements and that are approved by Centers for Medicare/Medicaid Services (CMS) to provide swing bed care, a separate provider number is needed for reimbursement from the Medicaid Program. When an application has been approved, the provider will receive a Long Term Care Facility handbook that explains the billing requirements particular to swing beds.

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type 131) and settled on a cost basis with other outpatient services. Prescription drugs must be billed on the outpatient pharmacy claim form.

3.1.3 Payment

Medicaid pays the billed charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient laboratory procedures, which are subject to the Medicaid pricing file, are paid at 62 percent of Medicare's prevailing rate.
- Diagnostic radiology services, ambulatory surgical center (ASC) services, and other services paid on a Medicaid fee schedule on an interim basis. For these services, a combination of the fee schedule and actual costs will be determined as payment at cost settlement.

Medicaid establishes an upper limit on reimbursement based on Medicare's reasonable cost. Payment will not exceed this limit.

Check eligibility to see if the client is enrolled in Healthy Connections (HC), Idaho's Medicaid Primary Care Case Management (PCCM) program. If a client is enrolled, guidelines must be followed to ensure reimbursement for providing Medicaid-covered services. Inpatient and outpatient services will require a referral from the HC primary care provider.

See **Section 1.5** for information on Healthy Connections

3.1.4 Type of Bill Codes

Enter one of the following codes (field 4 on the UB92 claim form). Use the code that best describes your claim:

111 Hospital Inpatient (Part A); admit through discharge

112 Hospital Inpatient (Part A); interim-first claim

113 Hospital Inpatient (Part A); interim-continuing claim

114 Hospital Inpatient (Part A); interim-last claim

117 Hospital Inpatient (Part A); replacement of prior claim (electronic claims only)

118 Hospital Inpatient (Part A); void/cancel of a prior claim (electronic claims only)

121 Hospital Inpatient (Part B); admit through discharge

122 Hospital Inpatient (Part B); interim-first claim

123 Hospital Inpatient (Part B); interim-continuing claim

124 Hospital Inpatient (Part B); interim-last claim

127 Hospital Inpatient (Part B); replacement of prior claim

128 Hospital Inpatient (Part B); void/cancel of a prior claim

131 Hospital Outpatient; admit through discharge

137 Hospital Outpatient; replacement of prior claim

138 Hospital Outpatient; void/cancel of a prior claim

141 Hospital Other (Part B); admit through discharge

151 Hospital Intermediate Care- Level 1; admit through discharge

721 Clinic – Hospital based or Independent Renal Dialysis Center; Admit through discharge End Stage Renal Disease (ESRD)

722 Clinic – Hospital based or Independent Renal Dialysis Center; Interim – first claim (ESRD)

723 Clinic – Hospital based or Independent Renal Dialysis Center; Interim – continuing claim (ESRD)

724 Clinic – Hospital based or Independent Renal Dialysis Center; Interim – last claim (ESRD)

831 Hospital Ambulatory Surgical Center (ASC) Surgery – ASC Services to Hospital Outpatient; admit through discharge

837 Hospital ASC Surgery – ASC Services to Hospital Outpatient; replacement of prior claim

838 Hospital ASC Surgery – ASC Services to Hospital Outpatient; void/cancel of prior claim

3.1.4.1 Type of Bill Codes for Outpatient Medicare Crossovers Only

Use one of the following types of bill codes for outpatient Medicare crossover claims.

135 Hospital Outpatient; Late Charge Only

137 Hospital Outpatient; Replacement of a Prior claim

851 Critical Access Hospital; Admit through discharge

3.1.5 Patient Status Codes

Enter one of the following codes (field 22 on the UB92 claim form).

01 Discharged to home or self care (routine discharge)

02 Discharged/transferred to another short-term general hospital

03 Discharged/transferred to skilled nursing facility (SNF)

04 Discharged/transferred to an intermediate care facility (ICF)

05 Discharged to another type of institution (including distinct part) or referred to another institution

06 Discharged/transferred to home under care of organized home health service organization (Indicate in field 84 the status or location of client and time they left the hospital)

07 Left against medical advice or discontinued care

08 Discharged/transferred to home under care of a home IV drug therapy provider

20 Expired (or did not recover)

30 Still a patient or expected to return for outpatient services

40 Hospice: expired at home

41 Hospice: expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice

42 Hospice: expired – place unknown

3.2 Inpatient Hospital Service Policy

3.2.1 Overview

Medicaid pays for inpatient services ordinarily furnished in a hospital for the care and treatment of a patient under a physician's direction or, under certain conditions, a dentist.

3.2.2 Inpatient Day

An inpatient day is counted for:

- A patient who is admitted to the hospital for inpatient services, intends to stay overnight, and is in the inpatient bed at the midnight census hour.
- A patient who is admitted for observation in a routine service, has stayed 24 hours, and is not ready to be discharged.

3.2.3 Reimbursement

Medicaid pays billed inpatient charges multiplied by an inpatient reimbursement rate. Medicaid establishes an upper reimbursement limit based on cost audit settlement set by Medicaid. Payment will not exceed this limit.

3.2.4 Accommodation Rates

3.2.4.1 Limitations

Birthing room charges should reflect the normal administrative, nursing, and physical resources utilized for the mother and child occupying the same room. Ancillary services may not be combined with the charge for the accommodation.

Private and psychiatric accommodations will not be reimbursed at more than the semiprivate room rates on file with Medicaid except as stated in **Section 3.2.4.2, Exceptions**.

If the client is placed in a private room for the hospital's convenience, Medicaid will pay the semiprivate room rate only. The client must not be billed for the amount in excess of the semiprivate rate.

Note: All inpatient services and charges for the same revenue code on the same date of service should be combined and billed on the same line of the UB92 claim form or the electronic claim screen.

3.2.4.2 Exceptions

Payment is limited to a semiprivate room accommodation rate; however, when the physician writes an order for a private room or isolation for the client because of medical necessity, Medicaid will pay the private room rate. A copy of the statement of medical necessity signed by the physician must be attached to the claim form.

3.2.4.3 Rate Changes

All changes in accommodation rate charges must be submitted to Medicaid on the hospital accommodation rate schedule form in **Section 3.2.8, Hospital Accommodation Rate Schedule**. Please make note of the revenue codes that require an accommodation rate listed in **Section 3.7.2, Accommodation Revenue Codes**.

3.2.5 Mental Health Hospital

Payment for inpatient services provided in a freestanding mental health hospital is limited to hospitals contracted with DHW under the authority of the Division of Family and Community Services serving clients less than twenty-

one (21) years of age. Limited outpatient hospital therapy benefits may be provided under revenue codes **914**, **915**, **916**, and **918**. Inpatient mental health services require prior authorization and must be under the direction of a physician in a facility accredited by the joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the State of Idaho or the state in which it provides services.

The Department will pay for medically necessary in-patient psychiatric services for clients under 21 years of age that have a DSM IV diagnosis with substantial impairment in thought, mood, perception or behavior. Both severity of illness and intensity of services criteria must be met for admission.

The Department or its designee must authorize admissions. Admission to an Institute for Mental Disease (IMD) for clients under age twenty-one (21) requires a pre-admission review prior to an elective admission, which is defined as an admission that is planned and scheduled in advance, and is not an emergency in nature.

Emergency admissions require authorization within one workday of the admission. An emergency for purposes of admission is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part of the individual, death or harm to the individual, or death or harm to another person.

Note: CHIP-B participants are not eligiblie for inpatient psychiatric services.

Refer to **CHIP-B Appendix section B.1.5** for covered **CHIP-B** services.

The hospital medical record of the admission must include documentation to support that the client's status upon admission meets the definition of an emergency as stated above. Requests for authorization of emergency admissions must include the same information as required for elective admissions.

The Department or its designee will establish the initial length of stay. An individual plan of care must be developed and implemented within seventy-two (72) hours of admission. The plan of care must improve the client's condition to the extent that acute psychiatric care is no longer necessary.

A hospital may request a continued stay review from the Department or its designee, but it must be no later than the date assigned by the Department or its designee. A plan of care must include documentation to support that treatment of the client's psychiatric condition continues to require services that can only be provided on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental disease.

Failure to request a pre-admission or continued stay review in a timely manner will result in a retrospective review conducted by the Department or its designee. The Department will assess penalties as defined in **Section 3.2.5.1**.

Participants with Medicaid Basic Plan Benefits are limited to ten (10) days of inpatient mental health services per year.

3.2.5.1 Penalties

HOSPITAL Penalty:

One day late	$260.00
Two days late	$520.00
Three days late	$780.00
Four days late	$1,040.00
Five or more days late	$1,300.00

PHYSICIAN - Penalty for Admitting Physician:

One day late	$50.00
Two days late	$100.00
Three days late	$150.00
Four days late	$200.00
Five or more days late	$250.00

3.2.6 Diagnostic Tests and Procedures

Physician-ordered, medically necessary, diagnostic tests and procedures related to the diagnosis and treatment of the client's medical condition(s) are reimbursable. Those tests and procedures include, but are not limited to:

- Laboratory tests
- Pathology tests
- Diagnostic radiology procedures
- Admission tests

Some procedures may require prior authorization (PA). Refer to **Section 3.4 Prior Authorization (PA)** for more information.

3.2.7 Billing Procedures

3.2.7.1 Medicare Crossover Clients

When a client has Medicare coverage, the hospital must bill Medicare first.

Part A claims do not automatically cross over from Medicare, so it is necessary to bill Medicaid on the UB92, with the Medicare EOB attached, or electronically with PES or another vendor's software. Part B claims should automatically cross over from Medicare to Medicaid. However if this does not happen, you can bill Medicaid electronically with the Medicare information.

See **Section 2.5** for billing instructions on Medicare crossover claims.

When a client has Part A Medicare only, it is not necessary to bill Medicare for Part B services. Bill Medicaid directly for the Part B services and indicate on the paper claim in field 84 of the UB92 that the client has Part A only. Examples of Part B services would include lab work and emergency department services.

3.2.7.2 Birth/Delivery Billing

When submitting a claim for the delivery of a child, the charges for both the mother and the child can be billed on one claim form with the mother's Idaho Medicaid ID number if both leave the hospital at the same time. Combine all charges for like revenue codes.

If either mother or child remains in the hospital, the claims must be billed separately and the child's services cannot be billed using the mother's ID number. If the child is admitted to the neonatal intensive care unit (NICU) anytime during the stay, the charges may not be combined with the mother's and must be billed separately.

3.2.7.3 Pregnancy Services

The Pregnant Women (PW) program is restricted to pregnancy-related services only.

See **Section 1.4.4**, for information on the PW program.

3.2.7.4 Split Billing

When billing on paper, a client's charges must occasionally be split out and billed on separate claims. Instances when a split billing would occur include:

- Change in client program eligibility
- Inpatient stays that span the hospital fiscal year end
- Portions of an inpatient stay which have been denied by the QIO (Quality Improvement Organization) or Idaho Medicaid
- Inpatient stays that reflect transfers to psychiatric or rehabilitation units assigned a different Medicaid provider number than the general hospital
- Inpatient discharges in which administratively necessary days are billed on an outpatient claim
- Hospital owned and operated ambulance services must be billed on a separate UB92 claim using type of bill 131

Any inpatient claim submitted with a statement "through date" that is less than the discharge date must have a client status of **30** to indicate that this is an interim billing.

Use MAVIS to verify changes in a client's eligibility. To access MAVIS, use one of these two numbers, depending on your location:

(208) 383-4310 from the Boise calling area, or
(800) 685-3757 outside the Boise calling area

For additional information regarding client eligibility, choose option 1. The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8 a.m. - 6 p.m. MT.

3.2.7.5 Multiple Rates

When multiple rates exist for the same accommodation revenue code, a separate revenue line should be used to report each rate and the same revenue code should be reported on each line. Failure to split out these multiple rates will result in payment at the lower rate.

Note: Most transplant services are not covered for **CHIP-B** participants

Refer to the **CHIP-B Appendix, section B.1.5** for service limitations for CHIP-B participants.

3.2.7.6 Donor/Transplants

Donor costs for bone, heart, liver, and kidney transplants should be billed using the client's name and ID number. Enter "donor charges" in the Remarks field of the claim form to prevent a denial of the claim as a duplicate. A liver transplant from a live donor is not covered by Medicaid.

3.2.8 Hospital Accommodation Rate Schedule

A copy of the hospital accommodation rate schedule is available in the Forms Appendix or by contacting EDS.

Contact an EDS provider enrollment representative through MAVIS (option 0, option 4) at:

(200) 383-4310 from the Boise calling area, or
(800) 685-3757 outside the Boise calling area

The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8 a.m. - 6 p.m. MT.

Return the form to: EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Provider Enrollment FAX: (208) 395-2198

3.3 Outpatient Hospital Service Policy

3.3.1 Overview

Outpatient services are services performed in the hospital for a client who does not require inpatient accommodations. The items or services must be medically necessary and performed by or under the direction of a physician or, under certain circumstances, a dentist.

Outpatient services are to be provided at a service location over which the hospital exercises financial and administrative control. *"Financial and administrative control"* means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill, and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location shall be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital).

Note: All similar revenue codes with the same dates of service, with the exception of revenue codes requiring CPT procedure codes, should be billed on one line of the outpatient claim form or the electronic claims screen.

Outpatient services can include the following:

- Preventative
- Diagnostic*
- Admission tests
- Therapeutic
- Rehabilitative
- Palliative
- Laboratory PA
- Pathological PA

PA Some services require prior authorization by the Department. Refer to **Section 3.4 Prior Authorization (PA)** for more information.

***** Radiology services must include the TC modifier.

The following revenue codes require the appropriate CPT or HCPCS procedure code and modifier combinations:

300 – 307	**561**	**831**
320 – 324	**569**	**841**
340 – 341	**610 – 618**	**851**
350 – 352	**634 – 636**	**924**
400 – 404	**657**	**942**
550	**771**	
559	**821**	

3.3.2 Reimbursement

Medicaid pays the covered charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient laboratory procedures, which are subject to the Medicaid pricing file, are paid at 62 percent of Medicare's prevailing rate.
- Diagnostic radiology services, ambulatory surgical center (ASC) services, and other services are paid at the Medicaid fee schedule rate on an interim basis. For these services, a combination of the fee schedule and actual costs will determine a blended rate for payment at cost settlement.

Medicaid establishes an upper limit on reimbursement based on Medicare's reasonable cost. Payment will not exceed this limit.

3.3.3 Outpatient Observation

Observation should be billed under the revenue code that reflects the service area in which the provider accounts for the client and the related costs (inpatient room, outpatient room or emergency room).

When a client is observed in an inpatient bed by staff assigned to the routine care area, revenue code **760** or **762** should be used to reflect the costs of the routine service area. Any client, who is in observation status in a routine service area after 24 hours, must be admitted at the beginning of the 25th hour.

Observation in a designated room or not in an inpatient bed should be billed under revenue code **760** or **762**.

Observation room and time may not be billed as a substitute for an emergency department visit or nursing services rendered outside the emergency department.

Observation time cannot be substituted for stays denied by the QIO when the intensity of services does not justify an inpatient day.

3.3.4 Professional Component

Medicaid has an arrangement with Medicare for the automatic billing by magnetic tape of additional coverage amounts for shared Medicare Part B/Medicaid clients. Hospital services related to the professional component of all ancillary services that are submitted to Medicare are automatically submitted, processed, and forwarded to Medicaid. If the patient is not dually eligible then the professional component of all ancillary services must be billed to the Idaho Medicaid program by the performing provider.

See **Section 2.4** for information on Crossover Claims.

See **Section 1.4.1** for information on Presumptive Eligibility.

3.3.5 Presumptive Eligibility (PE) and Pregnant Women (PW) Clinic

Presumptively eligible (PE) clients are only eligible for outpatient pregnancy-related services. Some Hospitals and District Health Departments are PW (Pregnant Women) Clinics. They must be a Medicaid approved provider and meet the conditions for presumptive eligibility of pregnant women. Additionally, approved providers must be trained and certified by the Department. For more information on the training process, please contact your local Department of Health and Welfare eligibility office.

3.3.6 Physical Therapy Limitations

Physical therapy visits are limited to 25 visits per calendar year regardless of the billing provider. If additional medically necessary visits are required, prior authorization must be obtained from:

Bureau of Medical Care
Physical Therapy Authorizations
P.O. Box 83720
Boise, ID 83720-0036

FAX: (208) 332-7280

3.3.7 Emergency Department (ED) Limitations

Payment for emergency department (ED) visits, revenue code 450, is limited to six (6) per calendar year. Count the ED visit as one unit unless the client is seen twice on the same day.

ED visits that are followed by an immediate admission to inpatient status should be billed as part of the inpatient service and will be excluded from the six-visit limit.

When total ED visits are exhausted, all other Medicaid covered charges on the claim form are still reimbursable.

3.3.8 Healthy Connections (HC)

Services performed in an ED do not require a Healthy Connections (HC) referral. Services billed on an Institutional claim with revenue code 450 and services billed on a Professional claim (with POS 23) are exempt from the HC referral requirement.

3.3.9 Billing Procedures

3.3.9.1 Medicare Crossover Clients

Medicare claims will automatically cross over from Medicare to Medicaid. However, if the claim does not automatically cross over, a copy of the Medicare Remittance Notice (MRN) must be attached to the claim form before submission to Medicaid. Providers can also submit electronic crossover claims using PES.

See **Section 2.3** for information on Crossover Claims.

3.3.9.2 Third Party Recovery

See **Section 2.3, Third Party Recovery**, regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid.

3.3.9.3 Oral Surgeons

Oral Surgeons who perform services in the hospital setting are required to bill CPT surgical codes on the Professional claim form using their physician provider number. Do not use CPT procedure code 41899 (unspecified code); it will cause a delay in payment for services. Extractions must be billed on an American Dental Association (ADA) claim form under the dental provider number, with the appropriate CDT dental code and tooth number. Do not bill on a Professional claim form for extractions.

3.4 Prior Authorization (PA)

3.4.1 Overview

The Idaho Medicaid program has contracted with Qualis Health (formerly PRO-West); a quality improvement organization (QIO), to conduct the medical and surgical reviews of inpatient and selected outpatient hospital services. The appropriateness and necessity of the client's admission and length of stay are subject to QIO review.

See **Sections 3.4.12 and 3.4.13** for a listing of the diagnosis and surgical procedure codes that require prior authorization (PA). Refer to the *Qualis Health Provider Manual* for details regarding review procedures.

The attending physician is ultimately responsible for obtaining preadmission approval (except for emergencies). However, the QIO will accept preadmission monitoring calls from the surgeon, physician office personnel, or facility personnel when applicable. HC participants require a referral from their primary care provider (PCP) for all inpatient and outpatient hospital services in addition to the QIO PA.

When billing, if PA is required, the PA number must be indicated on the claim. Enter the PA number in Field 63 on the UB92 claim form. For electronic claims, enter the PA number in the PA field on the screen. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval. For HC participants, PA will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

See **Section 1.7.7** for information on Prior Authorization.

See **Section 3.4.2** for information on authorization for emergency services.

3.4.2 Admitting and Principal Diagnoses

It is very important to include the admitting diagnosis code in field 76 and the principal diagnosis code in field 67 on the claim. These codes are used to determine if the admission requires QIO review.

If the admitting diagnosis and the principal diagnosis are different, and one of them is a condition that does require preadmission review, then the admission requires QIO preadmission review.

3.4.3 Length of Stay Review

Concurrent review is required when the admission exceeds day three (3), or day four (4) if the patient had a Cesarean Delivery, or the number of days assigned by the QIO for a procedure. In the event the admitting diagnosis is different from the principal diagnosis, the diagnosis that allows the greatest length of stay is used to determine the length of stay for the admission. When QIO approval has been given for a portion of the hospital stay, accommodation days are payable only to the QIO scheduled discharge date or the last approved day.

Example
If the discharge date is 08/15/2005 and QIO approved discharge is 08/14/2005, the last accommodation day to be covered by Medicaid would be 08/13/2005.

Although the room charge is not covered for 08/14/2005, the ancillary charges can be submitted with the stay. Medicaid would **not** pay the accommodation or ancillaries for 08/15/2005.

Note: Refer to the **CHIP-B Appendix**, **section B.1.5.1**, for limitations for inpatient psyciatric coverage for CHIP-B participants.

3.4.4 Transfers

QIO authorization is not required for transfers from hospital to hospital inpatient status (inter-facility).

Authorization is required for transfers into psychiatric, substance abuse, or rehabilitation units within the same hospital (intra-facility). The receiving unit is responsible for obtaining the authorization within one working day of the transfer. The sending unit is not required to obtain a transfer review.

3.4.5 Out-of-State Providers

All medical care provided outside the state of Idaho is subject to the same prior authorization and continued stay review requirements and restrictions as medical care provided within Idaho. See Section 3.4.12 and 3.4.13 for a list of diagnoses and procedures requiring PA review. If PA is required, the PA number must be indicated on the claim or that service will be denied.

The client's physician(s) or the treating facility may initiate the request for PA. The treating physician(s) and the treating facility are equally responsible for obtaining prior authorization.

Medicaid Transportation must prior authorize non-emergent transportation for out-of-state care. Providers may contact Medicaid Transportation at:

(800) 296-0509 ext. 1172 or 1173 within the Boise calling area

FAX: (800) 296-0513 or 334-4979 within the Boise calling area

3.4.6 Admission for Substance Abuse

With implementation of OBRA 90, Medicaid coverage of substance abuse includes certain inpatient detoxification and rehabilitation services.

QIO approval is required for inpatient services under either the psychiatric/chemical dependency admissions category (diagnosis codes **291.0-314.9**) or the rehabilitation admissions category (diagnosis code **V57.0-V57.9**).

3.4.7 Cesarean Section

When billing for a C-section, use the appropriate diagnosis code indicating the reason for the C-section. The following range of diagnoses in the table below have a four (4) day length of stay (LOS) and require a review with the Department's Quality Improvement Organization (QIO), Qualis Health, if the patient is not discharged after the fourth day.

Contact Qualis Health toll-free at (800) 783-9207 for a telephonic review or FAX your request to (800) 826-3836.

Diagnosis Code (Code to the 5th digit 642.5—663.4)	Description
642.5 *(0,1,2,4)*	Severe pre-eclampsia
652.2—652.8 *(0,1,3)*	Malposition and malpresentation of fetus
653.4 *(0,1,3)*	Fetopelvic disproportion
654.2 *(0,1,3)*	Abnormality of organs and soft tissues of pelvis, previous cesarean delivery
659.7 *(0,1,3)*	Abnormality in fetal heart rate or rhythm
660.0—660.8 *(0,1,3)*	Obstructed labor
661.00—661.43	Abnormality of forces of labor
663.1__663.3 *(0,1,3)*	Umbilical cord around neck, with compression

Diagnosis Code (Code to the 5th digit 642.5—663.4)	Description
663.4 *(0,1,3)*	Umbilical cord complications, short cord
763.4	Fetus or newborn affected by other complication of labor and delivery, cesarean delivery
V30.01	Single liveborn, born in a hospital, delivered by cesarean delivery
V31.01	Twin, mate liveborn, born in a hospital, delivered by cesarean delivery
V32.01	Twin, mate stillborn, born in a hospital, delivered by cesarean delivery
V33.01	Twin, unspecified, born in a hospital, delivered by cesarean delivery
V34.01	Other multiple, mates all liveborn, born in a hospital, delivered by cesarean delivery
V35.01	Other multiple, mates all stillborn, born in a hospital, delivered by cesarean delivery
V36.01	Other multiple, mates live- and stillborn, born in a hospital, delivered by cesarean delivery
V37.01	Other multiple, unspecified, born in a hospital, delivered by cesarean delivery

3.4.8 Medicaid/Medicare Eligibility

Some Medicare clients have both Medicare and Medicaid coverage for hospitalizations. For those clients with Part A Medicare (inpatient services), QIO review is not necessary if Medicare is the primary payer. Medicare guidelines should be followed. If, however, the client has only Part B Medicare (outpatient services), the admission is subject to QIO review because Medicaid is the primary payer for the inpatient services. Verify eligibility through MAVIS. To access MAVIS, use one of these two numbers, depending on your location:

For additional information regarding third party coverage, contact MAVIS at:

(208) 383-4310 from the Boise calling area, or
(800) 685-3757 outside the Boise calling area

The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8:00 a.m. – 6:00 p.m. MT.

3.4.9 Other Insurance

When the client has other insurance, QIO authorization is required, although the other insurance must be billed prior to Medicaid. Use MAVIS to verify other insurance coverage.

3.4.10 Retrospective/Late QIO Reviews

Retrospective review is a review of cases for clients who were not eligible at the time of the admission but who were determined eligible at a later date. In these cases, Medicaid will not assess penalties to the provider.

Reminder: Claims must be billed within one year of the date of service.

Late review is a review of cases where the client was eligible and prior authorization was not obtained prior to the hospital admission. Qualis Health accepts telephonic requests for late reviews only if the client is still in the hospital at the time Qualis Health is notified. If the client has already been discharged, providers must request a late review by submitting a Retrospective Review Request Form to Qualis Health with a copy of the history and physical, discharge summary, completed UB92 claim, and operative report (if applicable). Refer to the *Qualis Health Provider Manual, Exhibit 15* for a copy of the Request Form and additional instructions.

Medicaid may assess a penalty if a hospital does not secure a QIO review in a timely manner. These penalties are based on how late the review is made, as follows:

One day late = $260. 00

Two days late = $520. 00

Three days late = $780. 00

Four days late = $1,040. 00

Five days late = $1,300. 00

Qualis Health does not have authority to reverse late review penalties. Appeals regarding penalties should be directed to:

Office of Financial Recovery
P.O. Box 83720
Boise, ID 83720-0036

Phone (208) 287-1152

FAX: (208) 334-6515 or toll free (866) 849-3843

Mail all other Medicaid correspondence regarding QIO issues to:

Idaho Medicaid
Bureau of Medical Care
P.O. Box 83720
Boise, ID 83720-0036

FAX: (208) 332-7280

Or call (208) 287-1177

Monday through Friday (excluding holidays)

8:00 a.m. – 5:00 p.m. MT

3.4.11 Contacting Qualis Health

Qualis Health
PO Box 33400
Seattle, WA 98133-9075

To reach Qualis Health, call (800) 783-9207, press 122. FAX number (800) 826-3836. Monday-Friday between 7:30 a.m. and 6:45 p.m. (MT). Voice mail is available 24 hours a day, seven days a week. To access Qualis Health via the internet: **http://www.qualishealth.org/cm/idaho%2Dmedicaid/**.

3.4.12 Inpatient and Outpatient Psychiatric and Rehabilitation Diagnoses Requiring Prior Authorization (PA)

Inpatient and outpatient procedures that require QIO prior authorization include the following codes, when performed on Idaho Medicaid clients and children in the legal custody or legal guardianship of the State of Idaho, Division of Family and Children Services:

Note: Participants with Medicaid Basic Plan Benefits are limited to ten (10) days of inpatient mental health services per year.

Diagnosis Codes
Inpatient Psychiatric or Chemical Dependency Admissions (use fourth or fifth digit sub-classification): **291.0 through 314.9**
Inpatient Physical Rehabilitation Admissions: **V57.0-V57.9** **Note:** This includes admission to all rehabilitation hospitals, regardless of the diagnosis on the claim.

3.4.13 Inpatient and Outpatient Procedures Requiring QIO Prior Authorization (PA)

QIO prior authorization is also required for all elective or scheduled admissions when the client is admitted one (1) or more days prior to a planned surgery that is on the Select Prior Authorization list. See the Qualis Health Website for a complete listing of the select prior authorization list. The site is available at: **http://www.qualishealth.org/cm/idaho-medicaid/upload/cmid-selectpreauthlist.pdf**. The Select Prior Authorization List is also available on the Idaho Medicaid Provider Resources CD.

QIO review is required for all surgeries on the list, whether inpatient or outpatient.

3.4.14 Inpatient/Outpatient Prior Authorization (PA) by Medicaid

Medicaid PA is required for the following procedures:

- Reconstructive surgery not on the Qualis Health list
- Plastic surgery not on the Qualis Health list
- Cosmetic surgery not on the Qualis Health list
- Elective surgery not on the Qualis Health list
- Administratively Necessary days (AND)
- Excluded services found medically necessary in an EPSDT screen
- Physical therapy visits that exceed 25 visits per calendar year
- Genetic Pathology and Laboratory Testing

Refer to **Section 3.4.15** for the listing of medical and surgical procedure codes that require PA from Medicaid.

Send PA requests to:

Idaho Medicaid
Bureau of Medical Care
P.O. Box 83720
Boise, ID 83720-0036

FAX: (208) 332-7280

When billing, if PA is required, the PA number must be reported on the claim or the claim will be denied.

Healthy Connections clients require a referral from their primary care provider for all inpatient and outpatient hospital services in addition to a Medicaid or Qualis Health PA.

3.4.15 Medical Surgical Procedures Requiring Medicaid Prior-Authorization

Proc	Description
03.29	Other chordotomy
03.93	Implantation or replacement of spinal neurostimulator lead(s)
17106	Destruction of cutaneous vascular proliferative lesions; less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions; 10.0 - 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions; over 50.0 sq cm
19324	Mammoplasty, augmentation without prosthetic implant
19325	Mammoplasty augmentation with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis
19342	Delayed insertion of breast prosthesis
19350	Reconstruction, nipple/areola
19357	Breast reconstruct with tissue expander including subsequent expansion
19361	Breast reconstruct with latissimus dorsi flap, with or without prosthetic implant
19364	Breast reconstruction with free flap
19366	Breast reconstruction with other technique
19369	Brea t reconstruction
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19499	Unlisted procedure, breast
29999	Unlisted procedure, arthroscopy
30462	Rhinoplasty; tip, septum, osteotomies

Proc	Description
36475	Endovenous ablation therapy of incompetent vein, extremity, radiofrequency
36476	Endovenous ablation therapy of incompetent vein, second and subsequent
36478	Endovenous ablation therapy of incompetent vein, extremity, laser
36479	Endovenous ablation therapy of incompetent vein, second and subsequent
37700	Ligation & division of long saphenous vein
37718	Ligation, division, and stripping, short saphenous vein
37720	Ligation, division & complete stripping of long or short saphenous veins
37722	Ligation, division, and stripping, long (greater) saphenous veins
37730	Ligation, division & complete stripping of long and short saphenous veins
37735	Ligation, division & complete stripping of long or short saphenous veins, with excision of deep fascia
37760	Ligation of perforator veins, subfascial, radical, with or without skin graft, open
37780	Ligation & division of short saphenous vein at saphenopopliteal junction
37785	Ligation, division and/or excision of varicose vein cluster(s), one leg
38.59	Leg varicose veins ligation & stripping
43659	Laparoscopy, unlisted stomach procedure
43850	Revision of gastroduodenal anastomosis with reconstruction; without vagotomy
48160	Pancreatectomy, total or subtotal, with autologous transplantation
50.51	Auxiliary liver transplant, leaving patients own liver in situ
52640	Transurethral resection of postoperative bladder neck contracture
59866	Multifetal pregnancy reduction(s)
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to single electrode array
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
64573	Incision for implant of neuro electrodes; cranial nerve
64999	Unlisted procedure, nervous system

Proc	Description
69930	Cochlear device implant; with or without mastoidectomy
85.53	Unilateral breast implant
85.54	Bilateral breast implant
85.7	Total breast reconstruct
85.83	Breast full-thick graft
85.84	Breast pedicle graft
85.85	Breast muscle flap graft
85.87	Nipple repair nec
85.93	Breast implant revision
85.94	Breast implant removal
85.95	Insert breast tissue expander
85.96	Remove breast tissue expander
85.99	Breast operation nec
86.94	Insertion or replacement of single array neurostimulator pulse generator
86.95	Insertion or replacement of dual array neurostimulator pulse generator
86.96	Insertion or replacement of other neurostimulator pulse generator
86.97	Insertion or replacement, single array n.s. pulse generator, rechargeable
86.98	Insertion or replacement, dual array n.s. pulse generator, rechargeable
87903	Phenotype analysis by DNA/RNA, HIV 1, first through 10 drugs tested
87904	Phenotype analysis by DNA/RNA, HIV1, each additional 1 through 5 drugs
97799	Unlisted physical medicine/rehabilitation service or procedure
99.99	Other miscellaneous procedures; other

3.4.15.1 PET Scan (Positron Emission Tomography)

As of January 1, 2006, PET scans no longer require prior authorization (PA) from the Bureau of Medical Care. For questions regarding PAs, please call (208) 364-1904.

When billing for a PET Scan, bill with revenue code 404, the authorized HCPCS code, modifier TC.

3.4.16 Attachments

Inpatient attachments include the following:

- TPR — when billing on a paper claim form, attach the EOB statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate ARC codes from the other insurer; no attachment is required.

- Hysterectomies — authorization for hysterectomy and documentation of medical necessity
- Sterilizations — appropriately completed consent form
- Therapeutic abortions — completed Certification of Necessity
- Private room — statement of medical necessity or physician order

Outpatient attachments include:

- TPR — when billing on a paper claim form, attach the EOB statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate the ARC codes from the other insurer; no attachment is required.
- Sterilization — appropriately completed consent form

3.4.17 Hospital Physicians

Hospital-based physician billers should refer to the *Idaho Medicaid Provider Handbook* for Physicians/Osteopaths to submit professional claims.

3.5 Administratively Necessary Day (AND)

3.5.1 Overview

An Administratively Necessary Day (AND) is intended to allow a hospital the time for an orderly transfer or discharge of inpatients who are no longer in need of a continued acute level of care. Administratively Necessary Days (AND) may be authorized for inpatients that are awaiting placement in a Skilled Nursing Facility (SNF), Intermediate Care Facility for the Mentally Retarded (ICF/MR), in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

3.5.2 Prior Authorization (PA)

The hospital discharge planner, utilization reviewer, or attending physician must contact the Department of Health and Welfare's Medicaid Bureau of Medical Care by phone or fax to request an AND. The AND Intake Form must be submitted to the Bureau of Medical Care **prior** to the patient be decertified as needing acute hospital care. This can be done as soon as the discharge planner anticipates a possible discharge issue, even before the final non-certified date is known. The facility must supply the additional required documentation within 10 working days of the submitted request. If the AND is not necessary, due to a reversal of the possible non-certification, immediately notify the Bureau of Medical Care, at the number below, and the request will be voided. When billing the AND, the PA number must be indicated on the claim.

FORM AVAILABLE: The AND Intake Form is included in the Forms Appendix of this handbook.

To request an AND, FAX the AND Intake Form and required documentation to (208) 332-7280.

For questions, call (208) 364-1904 Monday through Friday (excluding holidays) from 8:00 a.m. – 5:00 p.m. MT

The following documentation is required for PA of an AND:

- AND Intake Form
- Summary of patient's medical condition
- Current history and physical
- Physician progress notes
- Statement as to why patient cannot receive necessary medical services in a non-hospital setting
- Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services

3.5.3 Retroactive Eligibility

Services provided to an individual will be deemed prior approved if the individual was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible. The service provided is approved by the Department with the same guidelines and documentation requirements as other PA requests for AND.

3.5.4 Notice of Decision

The Department will review each PA request and issue a decision and prior authorization number, which is faxed to the requesting provider. The Department will also issue a Notice of Decision letter for each PA request, which is mailed to the client and the requesting provider.

3.5.5 Billing Procedures

AND services must be billed on the Institutional claim form as an outpatient service. The first AND should be the same day the client was discharged from the inpatient acute level of care. The AND authorization number must be in PA field 63 of the claim.

The hospital should utilize the same billing procedure as is currently used for outpatient claims with the following exceptions when billing for an AND:

- Type of Bill (Field 4) use code 151
- Revenue Codes (Field 42)
- Supplies and ancillary charges (except those listed in **Section 3.5.6, Revenue Codes**) are part of the content of care.

3.5.6 Revenue Codes

Listed below are the only revenue codes that can be billed with an AND.

CPT Must list valid CPT laboratory procedure code.

QIO Authorization must be attached.

HOSP The ambulance must be owned and operated by the hospital

HCPCS Must list valid HCPCS code

280 — Oncology General	**470** — Audiology
289 — Oncology Other	**471** — Diagnostic
300 — Laboratory CPT	**472** — Treatment
301 — Chemistry CPT	**480** — Cardiology
302 — Immunology CPT	**481** — Cardiac Catheterization Lab
303 — Renal Client (Home) CPT	**482** — Stress Test
304 — Non-routine Dialysis CPT	**489** — Other Cardiology
305 — Hematology CPT	**540** — Ground Ambulance (Hospital based); Non-emergency
306 — Bacteriology/Microbiology CPT	**541** — Ambulance Supplies
307 — Urology CPT	**542** — Ground Ambulance; Emergency
310 — Lab Pathology	**544** — Ambulance Oxygen
311 — Cytology	**545** — Air Ambulance – all levels of Life Support
312 — Histology	**546** — Ground or Air Ambulance –Neonatal Services
314 — Biopsy	**547** — Ambulance Pharmacy
320 — Radiology-Diagnostics CPT	**549** — Ambulance EKG Services
321 — Angiocardiography CPT	**610** — MRI-Trunk and extensions CPT
322 — Arthrography CPT	**611** — MRI-Brain & Brainstem CPT

323 — Arteriography CPT	**612** — MRI-Spine & Spinal Cord CPT
324 — Chest X-ray CPT	**671** — Outpatient Special Residence Charges – Hospital Based—Administratively Necessary Day
330 — Radiology Therapy	**730** — EKG/ECG
331 — Chemotherapy Injected	**731** — Holter Monitor
332 — Chemotherapy Oral	**732** — Telemetry (Including Fetal Monitor)
333 — Radiation Therapy	**740** — EEG
335 — Chemotherapy IV	**750** — Gastro-Intestinal
340 — Nuclear Medicine CPT	**790** — Lithotripsy
341 — Diagnostic CPT	**811** — Living Donor-Kidney QIO
342 — Therapeutic – oral	**812** — Cadaver Donor-Kidney QIO
350 — CAT Scan CPT	**813** — Unknown Donor-Kidney QIO
351 — Head Scan CPT	**819** — Other Organ Acquisition QIO
352 — Body Scan CPT	**820** — Hemodialysis; Outpatient or Home
380 — Blood Services	**821** — Hemodialysis/Composite or other Rate CPT
381 — Packed Red Cells	**830** — Peritoneal Dialysis
382 — Whole Blood Cells	**831** — Peritoneal Composite CPT
383 — Plasma	**840** — CAPD, Outpatient or Home
384 — Platelet	**841** — CAPD Composite or other Rate CPT
385 — Leukocytes	**850** — CCPD Outpatient or Home
386 — Other Components	**851** — CCPD Composite or other Rate CPT
387 — Other Derivatives (Cryopricipitates)	**880** — Miscellaneous Dialysis
390 — Blood Storage and Processing	**881** — Ultrafiltration
391 — Blood Administration	**889** — Other Miscellaneous Dialysis
400 — Other Imaging Services CPT	**921** — Peripheral Vascular Lab
401 — Diagnostic Mammography CPT	**922** — EMG
402 — Ultrasound CPT	**923** — Pap Smear
403 — Screening Mammography CPT	**924** — Allergy Test CPT
404 — Positron Emission Tomography (PET) HCPCS	**925** — Pregnancy Test
410 — Respiratory Services	**946** — Air Fluidized Bed
460 — Pulmonary Function	**947** — Other Therapeutic Complex Medical Equipment

3.6 Coverage Limits

3.6.1 Excluded Services

Services excluded from Medicaid coverage include the following:

- Acupuncture services
- Biofeedback therapy
- Laetrile therapy
- Eye exercise therapy
- Surgical procedures on the cornea for myopia
- Cosmetic surgery; excluding reconstructive surgery, which has prior approval by the Department.
- Elective medical and/or surgical treatment, except for family planning services, without Departmental PA.
- Vitamin injections in the doctor's or other licensed prescriber's office that are not needed for a specific diagnosis
- Organ transplants; lung, pancreas, multiple organ, or other transplant considered investigative or experimental
- New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service. If these procedures are excluded by the Medicare program, they are also excluded from Medicaid payment.
- Treatment of complications, consequences or repair of any medical procedure, in which the original procedure was excluded from Medicaid coverage, unless the resultant condition is deemed life threatening as determined by Medicaid.
- Routine physical examinations for adults or examinations in connection with the attendance, participation, enrollment, or accomplishment of a program or for employment.
- Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial insemination, consultations, counseling, office exams, tuboplasties, and vasovasotomies.
- Naturopathic services.
- Abortions except when the mother's life is in jeopardy or in cases of rape or incest.

3.6.2 Restricted Procedures

3.6.2.1 Physical Therapy

Outpatient physical therapy visits that exceed 25 visits per calendar year require prior authorization from the Bureau of Medical Care. See **Section 3.3.6** for additional information.

3.6.2.2 Cosmetic Surgery

All cosmetic surgery must be medically necessary and have Medicaid prior authorization.

3.6.2.3 Obesity

Surgery for the correction of morbid obesity is covered only with PA from Qualis Health. Surgical procedures for weight loss will be considered when the client meets the criteria for morbid obesity as defined in the Rules Governing Medical Assistance, IDAPA 03.09.03. The client must also have one of the major life threatening complications of obesity:

- alveolar hypoventilation
- uncontrolled diabetes
- uncontrolled hypertension

For purposes of this subsection, "uncontrolled" means that there is inadequate compliance or response to a prescribed medical regimen. Other complications of obesity such as orthopedic treatment, skin and wound care are not considered justification for a surgical remedy.

Clients must have a psychiatric evaluation to determine the stability of personality at least three months prior to the date the surgery is requested. The client must understand and accept the resulting risks associated with the surgery.

All clients requesting surgery must have their physician send a complete history and physical exam, and medical records documenting the client's weight and efforts to lose weight by conventional means over the past five years for the request to be considered.

The documentation of life threatening complications per IDAPA 16.03.09.069.03 must be provided by a consultant specializing in pulmonary diseases, endocrinology, or cardiology/hypertensive illness. The consultant cannot be associated with the clinic nor have other affiliations with the surgeons who will perform the surgery or with the primary physician who refers the client for the procedure.

Abdominoplasty or panniculectomy is covered only with PA from the Qualis Health. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for PA includes, but is not limited to, all of the following:

- Photographs of the front, side and underside of the client's abdomen
- Documented treatment of the ulceration and skin infections involving the panniculus
- Documented failure of conservative treatment, including weight loss
- Documentation that the panniculus severely inhibits the client's walking
- Documentation that the client is unable to wear a garment to hold the panniculus up
- Documentation of other detrimental effects of the panniculus on the client's health such as severe arthritis in the lower body.

Note: Refer to the **CHIP-B Appendix, section B.1.5**, for transplant coverage limitations for **CHIP-B** participants.

3.6.2.4 Transplants

The Department may purchase organ transplant services for bone marrow, kidneys, hearts, intestines, and livers when provided by hospitals approved by the CMS for the Medicare program. The hospital must have completed a provider agreement with the Department. A liver transplant from a live donor is not covered by Medicaid.

The Department may purchase cornea transplants for conditions where such transplants have demonstrated efficacy. Transplants, except for cornea transplants, must be prior authorized by the QIO.

Hospitals should obtain and use a separate provider number issued by Idaho Medicaid for transplants. This allows the hospital to accurately receive the lesser of 96.5% of Reasonable Costs under Medicare's payment principals or customary charges.

The transplant costs for actual or potential living kidney donors are covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Donor costs for bone, heart, liver, and kidney transplants should be billed using the client's name and ID number. Enter "donor charges" in the Remarks field of the claim form to prevent a denial of the claim as a duplicate. A liver transplant from a live donor is not covered by Medicaid.

Payments for post-operation expenses of a donor will be limited to the period of actual recovery.

Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will **not** be covered.

Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered.

Refer to *IDAPA 16.03.09.081 Organ Transplants* for additional information.

3.6.2.5 Fertility

Procedures or testing for the inducement of fertility are not a benefit of the Medicaid program. This includes, but is not limited to:

- Artificial insemination
- Consultations
- Counseling
- Office exams
- Tuboplasties
- Vasovasotomies

3.6.2.6 Take Home Drugs

Outpatient take-home drug charges that exceed $4.00 must be billed on the Idaho Medicaid pharmacy claim form. Inpatient take-home drugs dispensed upon discharge must also be submitted on the pharmacy claim form. All outpatient take home drugs must have the NDC identified on the claim.

3.6.2.7 Examinations

Examinations for the following are not payable:

- Routine examinations, other than those associated with the EPSDT program
- Routine examinations, other than the periodic health risk assessment
- Examinations related to attendance, participation, enrollment, or accomplishment of a program
- Examinations related to employment

- Premarital examination

3.6.2.8 Inpatient Mental Health

Inpatient mental health services are limited to 10 days per year for participants with Medicaid Basic Plan Benefits.

3.6.3 Exceptions

Some excluded services/procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during an EPSDT screen. Such excluded services/procedures must be prior authorized by Medicaid.

Some examples of the services for which payment may be made are substance abuse treatment and private duty nursing in the client's home. Any service recognized under the provisions of the Social Security Act can be made available if the above conditions are met.

3.6.4 Mammography Services

Idaho Medicaid will cover screening or diagnostic mammography performed with mammographic equipment and staff that is considered certifiable or certified by the Bureau of Laboratories.

- Screening mammography will be limited to one (1) per calendar year for women who are forty (40) or more years of age.
- Diagnostic mammography will be covered when a physician orders the procedure for a patient of any age who is at high risk.

3.6.5 Freestanding Dialysis Units

Outpatient dialysis procedures provided by a freestanding dialysis facility should be billed on a UB92 claim form in the following manner:

- Report with bill-type 721 through 724. Refer to **Section 3.1.4** for more information.
- Medicare crossover claims (Medicare is primary insurance) cannot be sent electronically to Idaho Medicaid from Medicare and therefore, must be submitted to Idaho Medicaid on a paper claim form with the MRN from Medicare attached.
- Dialysis procedures are reported with the following revenue codes:

  821 outpatient dialysis; CPT code 90999 (hemodialysis composite or other rate)

  270 dialysis supplies (medical surgical supplies)

  272 special supplies (sterile supplies)

  634 Epoetin up to 10,000 units (one billing unit = 1000 units) [CPT]

  635 Epoetin over 10,000 units (one billing unit = 1000 units) [CPT]

  636 dialysis drugs [CPT] (drugs requiring detailed coding); use the appropriate corresponding J-code from the most current HCPCS book and attach the NDC detail attachment with the claim form (see Medicaid Information Release MA03-69)

  831 Peritoneal Composite Rate; 90945 or 90947 CPT

  841 CAPD Composite or Other Rate; 90945/ 90947 or 90993 CPT

  851 CCPD Composite or Other Rate; 90945/90947 or 90993 CPT

  CPT Must indicate a valid CPT procedure code when billing outpatient claims.

If billing using a date span, make sure the header date span is reflected in the detail dates. You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.

Note: If the dates of service are not consecutive, each date of service must be billed on a separate detail line.

3.7 Revenue Codes

3.7.1 Overview

All hospital services must be billed using the following unique, three-digit revenue codes. EDS will deny any claim with any other revenue codes entered.

3.7.2 Accommodation Revenue Codes

PO These revenue codes must have a signed physician's order attached to the claim form.

Rev Code	Service	Description	Patient Status
100	All Inclusive Room-Board plus Ancillary and Swing Bed	Not covered. Except in hospitals approved for swing bed status	
101	All Inclusive Room-Board		In
110	Private PO	Covered with medically necessary documentation.	In
111	Medical/Surgical/Gyn PO		In
112	Obstetric PO	When using this revenue code for birthing room accommodation, make sure the facility has an accommodation rate on file and specify *Birthing Room* in the Remarks field (Field 84) of the UB92 claim form.	In
113	Pediatric PO		In
114	Psychiatric PO		In
115	Hospice	Must be billed using hospice provider number.	
116	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
117	Oncology PO		In
118	Rehabilitation PO		In
119	Other	Not covered	
120	Room and Board, Semiprivate		In
121	Medical/Surgical/Gyn		In
122	Obstetric		In
123	Pediatric		In
124	Psychiatric		In
125	Hospice	Not covered	
126	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
127	Oncology		In
128	Rehabilitation		In
129	Other	Not covered	
130	Semiprivate — 3 and 4 Beds		In
131	Medical/Surgical/Gyn		In
132	Obstetric		In

Rev Code	Service	Description	Patient Status
133	Pediatric		In
134	Psychiatric		In
135	Hospice	Not covered	
136	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
137	Oncology		In
138	Rehabilitation		In
139	Other	Not covered	
140	Private (Luxury)PO		In
141	Medical/Surgical/Gyn (Luxury)PO		In
142	Obstetric (Luxury)PO		In
143	Pediatric (Luxury)PO		In
144	Psychiatric (Luxury)PO		In
145	Hospice	Not covered	
146	Detoxification (Luxury)PO	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
147	Oncology (Luxury)PO		In
148	Rehabilitation (Luxury)PO		In
149	Other	Not covered	
150	Room and Board, Ward		In
151	Medical/Surgical/Gyn		In
152	Obstetric		In
153	Pediatric		In
154	Psychiatric		In
155	Hospice	Not covered	
156	DetoxificationPO	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
157	Oncology		In
158	Rehabilitation		In
159	Other	Not covered	
160	Other Room and Board	Not covered	
164	Room and Board, Sterile EnvironmentPO		In
167	Self Care	Not covered	
169	Other	Not covered	
170	Nursery		In
171	Newborn-Level 1		In
172	Premature-Level II		In
173	Newborn-Level III		In
174	Newborn-Level IV-NICU		In
179	Other — Nursery	Not covered	

Rev Code	Service	Description	Patient Status
180	LOA	Not covered	
181	Reserved	Not covered	
182	Client Convenience	Not covered	
183	Therapeutic Leave	Not covered	
189	Other Leave of Absence	Not covered	
200	Intensive Care Unit (ICU)		In
201	Surgical		In
202	Medical		In
203	Pediatrics		In
204	Psychiatric		In
206	Post ICU	Not covered	
207	Burn Care		In
208	Trauma		In
209	Other Intensive Care	Not covered	
210	Coronary Care Unit (CCU)		In
211	Myocardial Infarction		In
212	Pulmonary Care		In
213	Heart Transplant		In
214	Post CCU	Not covered	
219	Other Coronary Care	Not covered	

3.7.3 Ancillary Revenue Codes

CPT Must indicate a valid CPT procedure code when billing outpatient claims.

HCPCS Must indicate a valid HCPCS procedure code when billing outpatient claims.

Rev Code	Service	Description	Patient Status
220	Special Charges	Not covered	
221	Admission Charge	Not covered	
222	Technical Support Charge	Not covered	
223	UR Service Charge	Not covered	
224	Late Discharge, Medically Necessary	Not covered	
229	Other Special Charges	Not covered	
230	Incremental Nursing Charge		In
231	Nursery		In
232	OB		In
233	ICU		In
234	CCU		In
235	Hospice	Must bill using hospice provider number	
239	Other	Not covered	
240	All Inclusive Ancillary	Not covered	
249	Other Inclusive Ancillary	Not covered	
250	Pharmacy		In/Out
251	Generic Drugs		In/Out
252	Nongeneric Drugs		In/Out
253	Take Home Drugs	Must be under $4.00. Do not reduce charge to $4.00 and bill as an outpatient service. Bill correct amount on the pharmacy claim form if amount exceeds $4.00.	Out
254	Drugs Incident to other Diagnostic Services	Not covered	
255	Drugs Incident to Radiology		In/Out
256	Experimental Drugs	Not covered	
257	Non-prescription		In/Out
258	IV Solutions		In/Out
259	Other Pharmacy	Not covered	
260	IV Therapy		In/Out
261	Infusion Pump		In/Out
262	IV Therapy Pharmacy Services		In/Out
263	IV Therapy/Drug/ Supply Delivery		In/Out
264	IV Therapy/Supplies		In/Out
269	Other IV Therapy	Not covered	
270	Medical/Surgical Supplies and Devices	Extraordinary volume on TPN with prior approval only	In/Out

Rev Code	Service	Description	Patient Status
271	Nonsterile Supply		In/Out
272	Sterile Supply		In/Out
273	Take Home Supplies	Not covered	
274	Prosthetic/Orthotic Devices	Medicaid pays for permanent or temporary medical prosthetics to reinforce or replace a biological part implanted through surgery. Devices must be prescribed by the physician. Devices without FDA approval are not covered. Document specific device information in the Remarks field (Field 84) of the UB92 claim form. See Section 3.1.4 of the **Ambulatory Surgical Center Guidelines** for more specific information	In/Out
275	Pacemaker		In/Out
276	Intraocular Lens		In/Out
277	Oxygen-Take Home	Not covered	
278	Other Implant	Document in the Remarks field (Field 84) of the UB92 claim form the specific device or implant used. See Section 3.1.4 of the **Ambulatory Surgical Center Guidelines** for more specific information	In/Out
279	Other Devices	Not covered	
280	Oncology General		In/Out
289	Oncology Other		In/Out
290	DME (other than rental)	Not covered	
291	Rental		Out
292	Purchase of New DME	Not covered	
293	Purchase of Used DME	Not covered	
294	Supplies/Drugs for DME	Not covered	
299	Other Equipment	Not covered	
300	Laboratory CPT		In/Out
301	Chemistry CPT		In/Out
302	Immunology CPT		In/Out
303	Renal Patient (Home) CPT		
304	Non-routine Dialysis CPT		In/Out
305	Hematology CPT		In/Out
306	Bacteriology & Microbiology CPT		In/Out
307	Urology CPT		In/Out
309	Other Laboratory	Not covered	
310	Laboratory Pathological		In/Out
311	Cytology		In/Out
312	Histology		In/Out
314	Biopsy		In/Out
319	Other	Not covered	
320	Radiology Diagnostic CPT		In/Out
321	Angiocardiography CPT		In/Out

Rev Code	Service	Description	Patient Status
322	Arthrography CPT		In/Out
323	Arteriography CPT		In/Out
324	Chest X-ray CPT		In/Out
329	Other	Not covered	
330	Radiology Therapeutic		In/Out
331	Chemotherapy - Injected		In/Out
332	Chemotherapy - Oral		In/Out
333	Radiation Therapy		In/Out
335	Chemotherapy - IV		In/Out
339	Other	Not covered	
340	Nuclear Medicine CPT		In/Out
341	Diagnostic CPT		In/Out
342	Therapeutic		In/Out
349	Other	Not covered	
350	CT Scan CPT		In/Out
351	Head Scan CPT		In/Out
352	Body Scan CPT		In/Out
359	Other CT Scans	Not covered	
360	Operating Room Services CPT		In/Out
361	Minor Surgery CPT		In/Out
362	Organ Transplant — Other than kidney		In/Out
367	Kidney Transplant		In/Out
369	Other OR Services	Not covered	
370	Anesthesia		In/Out
371	Anesthesia Incident to Radiology		In/Out
372	Anesthesia Incident to Other Diagnostic Services		In/Out
374	Acupuncture	Not covered	
379	Other Anesthesia	Not covered	
380	Blood		In/Out
381	Packed Red Cells		In/Out
382	Whole Blood		In/Out
383	Plasma		In/Out
384	Platelets		In/Out
385	Leukocytes		In/Out
386	Other Components		In/Out
387	Other Derivatives (Cryopricipitates)		In/Out
389	Other Blood	Not covered	
390	Blood Storage and Processing		In/Out
391	Blood Administration	(e.g., transfusions)	In/Out

Rev Code	Service	Description	Patient Status
399	Other Blood Storage/ Processing	Not covered	
400	Other Imaging Service CPT		In/Out
401	Diagnostic Mammography CPT	Must be physician ordered	In/Out
402	Ultrasound CPT		In/Out
403	Screening Mammography CPT	Physician's order is not required. Client must be age 40 or older.	In/Out
404	Position Emission Tomography (PET) HCPCS	Must report appropriate HCPCS code. See Information Release 2003-72	In/Out
409	Other Imaging Service	Not covered	
410	Respiratory Services		In/Out
412	Inhalation Services		In/Out
413	Hyperbaric Oxygen Therapy		In/Out
419	Other Respiratory Service	Not covered	
420	Physical Therapy	Indicate units by visits not modalities for outpatient services. Only 25 visits per calendar year are allowed, regardless of provider. 1 unit = 1 visit	In/Out
421	Visit Charge	Not covered	
422	Hourly Charge	Not covered	
423	Group Rate	Not covered	
424	Evaluation or Re-evaluation		In/Out
429	Other Physical Therapy	Not covered	
430	Occupational Therapy		In/Out
431	Visit Charge	Not covered	
432	Hourly Charge	Not covered	
433	Group Rate	Not covered	
434	Evaluation or Re-evaluation Occupational Therapy		In/Out
439	Other Occupational Therapy	Not covered	
440	Speech — Language Pathology		In/Out
441	Visit Charge	Not covered	
442	Hourly Charge	Not covered	
443	Group Rate	Not covered	
444	Evaluation or Re-evaluation Speech/Lang.		In/Out
449	Other Speech-Language Pathology	Not covered	
450	Emergency Room		In/Out
459	Other Emergency Room	Not covered	
460	Pulmonary Function		In/Out
469	Other Pulmonary Function	Not covered	
470	Audiology		In/Out

Rev Code	Service	Description	Patient Status
471	Diagnostic		In/Out
472	Treatment		In/Out
479	Other Audiology	Not covered	
480	Cardiology		In/Out
481	Cardiac Cath Lab		In/Out
482	Stress Test		In/Out
483	Echocardiology		In/Out
489	Other Cardiology		In/Out
490	Ambulatory Surgical Care	Must report appropriate CPT or HCPCS when applicable	Out
499	Other ASC Care	Not covered	
500	Outpatient Services		Out
509	Other — Outpatient Services	Not covered	
510	Clinic	Not covered	
511	Chronic Pain Center	Not covered	
512	Dental Clinic	Not covered	
513	Psychiatric Clinic	Not covered	
514	OB-GYN Clinic	Not covered	
515	Pediatric Clinic	Not covered	
519	Other Clinic	Not covered	
520	Free Standing Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form	
521	Rural Health — Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form	
522	Rural Health — Home	Service not covered on this claim type. Must bill on a CMS 1500 form	
523	Family Practice Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form	
529	Other Free Standing Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form	
530	Osteopathic Services	Not covered	
531	Osteopathic Therapy	Not covered	
539	Other Osteopathic Service	Not covered	
540	Ambulance: Ground Ambulance Non-emergency	Hospital owned and operated ambulance services should be billed using the hospital's Medicaid provider number. Requires Medicaid Ambulance Review authorization	Out
541	Ambulance Supplies		Out
542	Medical Transport: Ground Ambulance Emergency	Hospital owned and operated ambulance services should be billed using the hospital's Medicaid provider number. Requires Medicaid Ambulance Review authorization	Out
543	Heart Mobile	Not Covered	
544	Ambulance Oxygen	Includes oxygen-related equipment	Out

Rev Code	Service	Description	Patient Status
545	Air Ambulance- All Levels of Life Support		Out
546	Neonatal Ambulance Services: Ground or Air Ambulance		Out
547	Ambulance Pharmacy		Out
548	Ambulance EKG Services	Telephone transmission EKG	Out
549	Other Ambulance	Respond and evaluate	Out
550	Skilled Nursing (S9123) HCPCS Requires modifier "U5"	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only. Not to exceed two visits per pregnancy. Also used to bill home health services. Must bill using home health provider number.	In/Out
551	Skilled Nursing Visit	Must bill using home health provider number.	
552	Hourly Charge	Not covered	
559	Maternity Nursing Visits (T1001) HCPCS Requires modifier "U5"	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only. Not to exceed two visits.	
560	Medical Social Services		In
561	Individual & Family Social Services (S9127) HCPCS Requires modifier "U5"	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only. Not to exceed two visits.	Out
562	Hourly Charge	Not covered	
569	Risk Reduction Follow-up (G9005) HCPCS	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only.	Out
570	Home Health Aide	Not covered	
571	Home Health Visit Charge	Home Health claims are billed on a UB92.	Out
572	Hourly Charge	Not covered	
579	Other Home Health Aide	Not covered	
580	Other Visits — Home Health	Not covered	
581	Visit Charge	Not covered	
582	Hourly Charge	Not covered	
589	Other Home Health Visits	Not covered	
590	Units of Service — Home Health	Not covered	
599	Home Health — Other Units	Not covered	
600	Oxygen — Home Health	Not covered	
601	Oxygen — Equipment, Supply, Cont.	Not covered	
602	Oxygen — State, Equipment, Supply, Under 1 LPM	Not covered	
603	Oxygen — State, Equipment, Over 4 LPM	Not covered	
604	Oxygen — Portable Add-on	Not covered	
610	MRT CPT		In/Out

Rev Code	Service	Description	Patient Status
611	MRI — Brain and Brainstem CPT		In/Out
612	MRI — Spine and Spinal Cord CPT		In/Out
614	MRI – Other CPT		In/Out
615	MRA – Head and Neck CPT		In/Out
616	MRA – Lower extremities CPT		In/Out
618	MRA – Other CPT		In/Out
619	Other MRT	Not covered	
621	Supplies Incident to Radiology		In/Out
622	Supplies Incident to Other Diagnostic Services		In/Out
623	Surgical Dressings		In/Out
630	Drug Home IV Sol.	Not covered	
631	Single Source	Not covered	
632	Multiple Source	Not covered	
633	Restrictive Prescription	Not covered	
634	EPO < 10000 Units CPT	Less than 10,000 units	Out
635	EPO > 10000 Units CPT	10,000 or more units	Out
636	Drugs Requiring Detailed Coding CPT		Out
640	IV Therapy Services	Not covered	
641	Non-routine Nursing, Central Line	Not covered	
642	IV Site Care, Central Line.	Not covered	
643	IV Start/Change, Peripheral Line	Not covered	
644	Non-routine Nursing, Peripheral Line	Not covered	
645	Training Client/Caregiver, Central Line	Not covered	
646	Training Disabled Client, Central Line	Not covered	
647	Training Client Caregiver, Peripheral Line	Not covered	
648	Training Disabled Client, Peripheral Line	Not covered	
649	Other IV Therapy Services	Not covered	
650	Hospice Services	Must bill using hospice provider number	
651	Routine Home Care	Must bill using hospice provider number	
652	Continuous Home Care	Must bill using hospice provider number	
655	Inpatient Respite Care	Must bill using hospice provider number	
656	General Inpatient Care	Must bill using hospice provider number	
657	Physician Services CPT	Must bill using hospice provider number	
659	Other Hospice	Must bill using hospice provider number	
660	Respite Care/HHA	Not covered	

Rev Code	Service	Description	Patient Status
661	Hourly Charge/Skilled Nursing	Not covered	
662	Hourly Charge/Home Health	Not covered	
671	Outpatient Special Residence Charges – Hospital Based – Administratively Necessary Day		Out
700	Cast Room		In/Out
709	Other Cast Room	Not covered	
710	Recovery Room		In/Out
719	Other Recovery Room	Not covered	
720	Labor Room/Delivery		In/Out
721	Labor		In/Out
722	Delivery		In/Out
723	Circumcision		In/Out
724	Birthing Center	Charge must reflect a service area not an accommodation (inpatient bed, etc.)	In/Out
729	Other Labor/Delivery	Not covered	
730	EKG/ECG		In/Out
731	Holter Monitor		In/Out
732	Telemetry (Including Fetal Monitor)		In/Out
739	Other EKG/ECG	Not covered	
740	EEG		In/Out
749	Other EEG	Not covered	
750	Gastro-Intestinal Services		In/Out
759	Other Gastro-Intestinal	Not covere.	
760	Treatment/ Observation Room		In/Out
761	Treatment Room		In/Out
762	Observation Room		In/Out
769	Other Treatment Room	Not covered	
771	Vaccine Administration [CPT]		Out
790	Lithotripsy		In/Out
799	Other Lithotripsy	Not covered	
800	Inpatient Renal Dialysis		In
801	Inpatient Hemodialysis		In
802	Inpatient Peritoneal (Non-CAPD)		In
803	Inpatient CAPD		In
804	Inpatient CCPD		In
809	Other Inpatient Dialysis	Not covered	
810	Organ Acquisition		In/Out
811	Living Donor	A liver transplant from a live donor is not covered by Medicaid	In/Out
812	Cadaver Donor		In/Out
813	Unknown Donor		In/Out

Rev Code	Service	Description	Patient Status
814	Unsuccessful Organ Search – Donor Bank Charges	Used only when costs incurred for an organ search does not result in an eventual organ acquisition and transplantation.	In/Out
815	Cadaver Donor		In/Out
816	Other Heart Acquisition		In/Out
817	Donor-Liver	A liver transplant from a live donor is not covered by Medicaid	In/Out
819	Other Organ Acquisition		In/Out
820	Hemodialysis Outpatient or Home		Out
821	Hemodialysis/Composite or Other Rate CPT		Out
822	Home Supplies	Not covered	
823	Home Equipment	Not covered	
824	Maintenance 100%	Not covered	
825	Support Services	Not covered	
829	Other Outpatient Hemodialysis	Not covered	
830	Peritoneal Dialysis – Outpatient or Home		Out
831	Peritoneal/Composite CPT or Other Rate		Out
832	Home Supplies	Not covered	
833	Home Equipment	Not covered	
834	Maintenance 100%	Not covered	
835	Support Services	Not covered	
839	Other Outpatient Peritoneal	Not covered	
840	CAPD Outpatient or Home		Out
841	CAPD Composite or Other Rate CPT		Out
842	Home Supplies	Not covered	
843	Home Equipment	Not covered	
844	Maintenance 100%	Not covered	
845	Support Services	Not covered	
849	Other Outpatient CAPD	Not covered	
850	CCPD Outpatient or Home		Out
851	CCPD/Composite or Other Rate CPT		Out
852	Home Supplies	Not covered	
853	Home Equipment	Not covered	
854	Maintenance 100%	Not covered	
855	Support Services	Not covered	
859	Other Outpatient CCPD	Not covered	
880	Miscellaneous Dialysis		In/Out
881	Ultrafiltration		In/Out

Rev Code	Service	Description	Patient Status
882	Home Dialysis Aid Visit	Not covered	
889	Other Miscellaneous Dialysis		In/Out
890	Other Donor Bank		In/Out
891	Bone		In/Out
892	Organ Other than Kidney, Liver and Heart		In/Out
893	Skin	Not payable if for cosmetic surgery	In/Out
899	Other Donor Bank	Not covered	
900	Psychiatric/Psychological Treatments	Not covered	
901	Electroshock Treatment		In/Out
902	Milieu Therapy	Not covered	
903	Play Therapy	Not covered	
904	Activity Therapy	Not covered	
909	Other	Not covered	
910	Psychiatric Services	Not covered	
911	Rehabilitation	Not covered	
912	Partial Hospitalization – Less Intensive	Not covered	
913	Partial Hospitalization - Intensive	Not covered	
914	Individual Psychiatric Therapy		In/Out
915	Group Psychiatric Therapy		In/Out
916	Family Psychiatric Therapy		In/Out
917	Bio Feedback	Not covered	
918	Testing Psychiatric Services		In/Out
919	Other	Not covered	
920	Other Diagnostic Services	Document specific diagnostic services rendered	In/Out
921	Peripheral Vascular Lab		In/Out
922	EMG		In/Out
923	Pap Smear		In/Out
924	Allergy Test CPT/HCPCS		In/Out
925	Pregnancy Test		In/Out
929	Other Diagnostic Services	Not covered	
940	Other Therapeutic Services	Document specific therapeutic services rendered	In/Out
941	Recreational Therapy		In
942	Education/Training HCPCS	For Diabetes Education and Training, use HCPCS G0108 for Individual Counseling and G0109 for Group Counseling. For PW or EPSDT nutritional services use S9470. See **Section 3.11, Diabetes Education and Training** or **Section 3.12 Dietician Policy** for more information.	Out

Rev Code	Service	Description	Patient Status
943	Cardiac Rehabilitation	Only payable within six weeks of heart surgery. Indicate the date of surgery and document specific cardiac rehabilitation services rendered.	In/Out
944	Drug Rehabilitation		In/Out
945	Alcohol Rehabilitation		In/Out
946	Complex Medical Equipment – Routine	e.g., Air Fluidized Support Bed	In/Out
947	Complex Medical Equipment – Ancillary		In/Out
949	Other Therapeutic Service	Not covered	
960	Professional Fees	Service not covered on this claim type. Must bill on a CMS 1500 form	
961	Psychiatric	Service not covered on this claim type. Must bill on a CMS 1500 form	
962	Ophthalmology	Service not covered on this claim type. Must bill on a CMS 1500 form	
963	Anesthesiologist (MD)	Service not covered on this claim type. Must bill on a CMS 1500 form	
964	Anesthetist (CRNA)	Must bill on a CMS 1500 using the CRNA's provider number, unless there is a Medicare exception to bill using the UB92	In/Out
969	Other Professional Fees	Service not covered on this claim type. Must bill on a CMS 1500 form	
971	Laboratory	Service not covered on this claim type. Must bill on a CMS 1500 form	
972	Radiology Diagnostic	Service not covered on this claim type. Must bill on a CMS 1500 form	
973	Radiology — Therapeutic	Service not covered on this claim type. Must bill on a CMS 1500 form	
974	Radiology — Nuclear Medicine	Service not covered on this claim type. Must bill on a CMS 1500 form	
975	Operating Room	Service not covered on this claim type. Must bill on a CMS 1500 form	
976	Respiratory Therapy	Service not covered on this claim type. Must bill on a CMS 1500 form	
977	Physical Therapy	Service not covered on this claim type. Must bill on a CMS 1500 form	
978	Occupational Therapy	Service not covered on this claim type. Must bill on a CMS 1500 form	
979	Speech Pathology	Service not covered on this claim type. Must bill on a CMS 1500 form	
981	Emergency Department	Service not covered on this claim type. Must bill on a CMS 1500 form	
982	Outpatient Services	Service not covered on this claim type. Must bill on a CMS 1500 form	
983	Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form	
984	Medical Social Services	Service not covered on this claim type. Must bill on a CMS 1500 form	

Rev Code	Service	Description	Patient Status
985	EKG	Service not covered on this claim type. Must bill on a CMS 1500 form	
986	EEG	Service not covered on this claim type. Must bill on a CMS 1500 form	
987	Hospital Visit	Service not covered on this claim type. Must bill on a CMS 1500 form	
988	Consultation	Service not covered on this claim type. Must bill on a CMS 1500 form	
989	Private Duty Nurse	Not covered	
990	Patient Convenience Items	Not covered	
991	Cafeteria/Guest Tray	Not covered	
992	Private Linen Service	Not covered	
993	Telephone/Telegraph	Not covered	
994	TV/Radio	Not covered	
995	Non-patient Room Rentals	Not covered	
996	Late Discharge Rate	Not covered	
997	Admission Kit		In
998	Beauty/Barber Shop	Not covered	
999	Other Client Convenience	Not covered	

3.8 Ambulatory Surgical Procedures/CPT Codes

3.8.1 Ambulatory Surgical Care

Medicaid allows interim payments for specific outpatient surgical procedures using the Medicaid fee schedule for ambulatory surgical centers (ASC). This section will be updated periodically with revisions appearing in the newsletters from EDS. The CPT codes listed for the ASC procedures must match the CPT codes used by the primary physician's billing.

ASC procedures should be submitted with type of bill **831** using revenue code **490** with the appropriate five-digit CPT code in the corresponding procedure code field. Revenue code **490**, ambulatory surgical care, is used to represent operating room charges. Each claim must identify the charges for each ancillary service by the revenue code that describes the service. For example, charges for the operating room (**490**), recovery room (**710**), medical supplies (**270-272**), anesthesia (**370-372**), or drugs (**250-253, 255**) would be listed in the charge column.

3.8.2 Multiple Procedures

Multiple ASC procedures must be listed separately with a CPT code for each procedure. It is not necessary to break out the operating room charges for each line that a procedure is billed under revenue code **490**. The hospital may list all ASC procedures with only one total charge per revenue code. Any ASC procedure code billed with revenue code **490** may display the total operating room charges. Each of the other lines billing operating room revenue code **490** with an ASC procedure code may have a total charge of zero entered. Other ancillary services "Included In" the procedure(s) must be billed with the related total customary charges on each line. Ancillary charges must not be bundled into revenue code **490**.

Note: Refer to the **CHIP-B Appendix, section B.1.5**, for transplant coverage limitations for CHIP-B participants.

Payment for multiple ASC procedures will be made at 100 percent of the price on file for the highest fee according to Medicaid's fee for service schedule. Subsequent procedures will be paid at 50 percent of the fee schedule.

3.8.2.1 Non-ASC Procedures

Procedures not included in Medicaid's list of ASC procedures should be billed with type of bill **131** and revenue code **360** or **361**.

Claims with multiple procedures that have at least one procedure not on the ASC list become outpatient claims payable at the outpatient reimbursement rate on file for that particular hospital. This does not include office procedures.

If an ASC procedure and a non-ASC procedure are performed at the same time, report all procedures, including the ASC procedure, on bill type 131 with revenue code 360 or 361.

3.8.3 Included In with Bill Type 831

Certain revenue codes are considered to be included in the global fee for the procedure when billed with type of bill 831 and will not be paid separately. The following revenue codes will be denied as "Included In" the global fee.

230	260	370	386	552	760
239	261	371	387	622	761
250	262	372	390	700	762
251	263	380	391	710	920
252	264	381	450	720	
253	270	382	500	721	
255	271	383	510	722	
257	272	384	519	723	
258	276	385	550	750	

Charges for revenue codes that are not considered part of the global fee should be billed on a separate claim with type of bill 131. Include justification on the claim or in the narrative field on ECS claims. Laboratory and radiology fees are paid at Medicaid's fee schedule. Revenue codes that are not on the "Included In" list are paid at the outpatient reimbursement rate on file.

3.8.4 Bundling

Charges for ASC claims should not be bundled under revenue code **490**. All charges should be listed under the appropriate revenue codes as on outpatient claims. Charges denied as "Included In" are calculated as part of the tally in determining payment at the time cost settlement occurs.

3.8.5 Dental Procedures

Healthy Connections clients require a referral from their primary care provider for any dental services provided in a hospital or ASC.

Medicaid reimburses for all of these services with a single fee under the surgical procedure code 41899. Use the procedure code 41899 when billing for prior authorized dental procedures.

When billing for dental services performed in the outpatient setting, use bill type **831**, revenue code **490,** and procedure code **41899**.

3.8.6 Ambulatory Surgical CPT Codes

See the Department of Health and Welfare Website for a complete listing of approved ambulatory surgical CPT codes and payment levels. The site is available at: **www.healthandwelfare.idaho.gov**. From the left-hand column, select Medical>Medicaid Providers>Medicaid Fee Schedule. In the center column, scroll down and select Ambulatory Surgical Centers.

The specific address for the ASC Medicaid Fee Schedule is: **http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3502/DesktopDefault.aspx**.

Consult your CPT manual for complete descriptions of the codes.

3.9 Ambulance Service Policy

3.9.1 Overview

Hospital based ambulance service is payable only if used in the event of an emergency situation or after prior authorization has been obtained from the Department, Medicaid Ambulance Review. Medicaid Ambulance Review manages ambulance transportation services, including PA of non-emergency ambulance transportation and retrospective medical review of emergency ambulance claims.

Note: Refer to the **CHIP-B Appendix, section B.1.5** for transportation coverage for CHIP-B participants.

Phone: (208) 287-1155 or (800) 362-7648

FAX: (208) 334-5242 or (800) 359-2236

3.9.1.1 Definition of Emergency Services

Medical necessity is established when the client's condition is of such severity that use of any other method of transport would endanger the client's life or health. An emergency exists when the severity of the medical situation is such that the usual PA procedures are not possible because the client requires immediate medical attention.

3.9.1.2 Definition of Non-emergency Service

Medicaid defines non-emergency service as scheduled transportation provided when the physical condition of the client requires ambulance transport and another form of transportation will place the client's life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the client's home from the hospital.

Transportation of a client residing in a long-term care facility is the responsibility of the long-term care facility, unless the condition of the client requires ambulance transport and PA has been obtained. If PA is required, the PA number must be included on the claim or the service will be denied.

3.9.2 Licensing Requirements

Ambulance services providers must hold a current license issued by Emergency Medical Services (EMS) according to the level of training and expertise personnel maintain, and must comply with the rules governing EMS services. Ambulance services providers based outside the state of Idaho must hold a current license issued by that state's EMS licensing authority. No payment will be made to ambulance services providers that do not hold a current license.

EMS Phone: (208) 334-4000

FAX: (208) 334-4015

3.9.3 Billing Information

Hospital based providers must bill on the UB-92 claim form using hospital revenue codes 540-549. See **Section 3.7.3** for more information on these revenue codes.

Both ground and air ambulance services owned and operated by hospitals must bill on the UB-92 using hospital revenue codes. UB-92 claim forms are

available from local form suppliers. These claims may also be submitted electronically by diskette or modem.

Required attachments include third party explanations of benefits (EOB) for other insurance payments and denials.

3.9.3.1 Third Party Recovery (TPR)

Required attachments to UB92 claim forms include third party EOB for other insurance payments and denials. If billing electronically, then the attachment is **not** required. However, the correct ARC codes and other insurance information must be submitted. See **Section 2** for information on Medicaid policy on billing all other TPR resources before submitting claims to Medicaid.

3.9.3.2 Medicare Clients

If a client has Medicare coverage, the provider must first bill Medicare for services rendered. See **Section 2, Third Party Recovery, Crossover Claims**, for billing instructions.

3.9.3.3 Submit the Claim to EDS

Authorized claims are submitted to EDS for payment. The providers claim form must match the information on the *Notice of Decision* or claims will be denied.

3.9.4 Covered Services

3.9.4.1 Air Ambulance

Air ambulance services are covered when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the client to the nearest appropriate facility and speedy admission is essential.
- The client's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and would be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by Medicaid Ambulance Review in advance except in emergency situations.

If the aircraft is owned and operated by a hospital, the service must be billed on a UB92 using appropriate revenue codes. Air ambulance services not owned by a hospital must bill on the CMS-1500 claim form, using HCPCS procedure codes.

3.9.4.2 Ground Ambulance

Ambulance services, which are owned and operated by a hospital, must be billed on the UB92 using hospital revenue codes. All other ambulance providers must submit claims on the CMS-1500 claim form using HCPCS procedure codes.

3.9.4.3 Waiting Time and Extra Attendants

Waiting time and extra attendants are not paid unless medically necessary, and authorized by Medicaid Ambulance Review. Waiting time must be physician-ordered.

3.9.4.4 Oxygen

Medicaid pays for oxygen when used by the patient during transport. This rate includes disposables such as masks or cannulae.

3.9.4.5 Multiple Runs in One Day

When the ambulance has transported a client, returned to the base station, and transported the same patient to another facility: two base rate charges will be allowed.

When the ambulance has transported a patient, the same patient is transferred to another facility, and the ambulance has not returned to the base station: one base rate will be allowed. Waiting time must be included in the base rate.

When the ambulance responds to a patient's home for two emergencies in a single day and transports the patient to the hospital twice: two base rates will be allowed. Indicate on the claim in the comments field that there were multiple runs on the same day.

3.9.4.6 Round Trip

Medicaid allows round trip charges when a hospital inpatient goes to another hospital to obtain specialized services not available in the original hospital and the referral hospital is the nearest one with such facilities.

Medicaid places restrictions on round trip charges, depending on whether the ambulance returns to the base station between trips.

- When the ambulance does not return to base station, bill for one base rate, including waiting time, limited to one and one-half (1½) hours.
- When the ambulance does not wait but returns to the base station between trips, bill for two base rates.

Contact Medicaid Ambulance Review for questions about:

- Notice of Decision
- Reconsideration of decision
- Appeal process

(208) 287-1155
(800) 362-7648

3.9.4.7 Physician in Attendance

In some situations a physician in attendance will be justified. When a physician is in attendance, the documentation should justify the necessity and indicate the specialty type of the physician. Physicians are responsible for billing their own services.

3.9.4.8 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when the requested service has been prior authorized by Medicaid Ambulance Review. Payment for any non-covered service is the responsibility of the facility.

3.9.4.9 Trips to Physician's Office

Ambulance service from a client's home to a physician's office is not covered unless it has been prior authorized by Medicaid Ambulance Review.

3.9.4.10 Treat and Release, and Respond and Evaluate

A treat and release payment may be authorized if the client is treated at the scene and not transported. Disposable supplies used at the scene are also covered. Medicaid Ambulance Review may downgrade a claim to a non-emergency service if the client was transported but the transport has been determined not medically necessary.

A non-emergency service may be authorized if the ambulance responds to the scene and evaluates the client, but no treatment or transport is necessary. Medicaid Ambulance Review may also downgrade a claim to a non-emergency service if the client was transported but the transport has been determined not medically necessary.

3.9.4.11 Deceased Clients

Ambulance service for deceased clients is covered when documented in the run sheet as follows:

- If the client was pronounced dead after the ambulance was called but before pickup, a base rate will be allowed.
- If the client was pronounced dead while in route to or upon arrival at the hospital, a base rate and mileage will be allowed.

3.9.5 Reimbursement Information

3.9.5.1 Customary Fees

Medicaid reimburses hospital owned and operated ambulances on a cost basis and all other ambulance providers on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

Transportation of nursing home clients is considered part of the content of nursing home care and therefore is the responsibility of the nursing home, unless the condition of the client requires ambulance transport. All non-emergency transports must be prior authorized by Medicaid Ambulance Review. For more information on prior authorizations, refer to **Section 3.10.6, Ambulance Service Prior Authorization.**

See **Section 2** for information on crossover claims.

3.9.5.2 Base Rate for Ambulances

Levels of Service

There are three levels of service that providers may request when seeking reimbursement for patient transports, and treat and release (non transport):

- Non-Emergency services, including Treat and Release or Respond and Evaluate
- Emergency services
- Neonatal ambulance services

When reviewing and authorizing a particular level of service Medicaid Ambulance Review must consider if either:

- an emergency existed; or
- if the patient was transported/not transported, the services rendered were medically necessary

Separate fees are allowed for supplies, oxygen, pharmacy items, and EKG (see **Section 3.7.3** for revenue codes 540-549). Mileage must be included in the base rate.

3.9.6 Ambulance Service Prior Authorization (PA)

Medicaid Ambulance Review operates a transportation management system for medical transportation services. This includes PA of non-emergency ambulance and the retrospective medical review of emergency transport by ambulance. Any Medicaid claim for ambulance services must include an authorization number from Medicaid Ambulance Review when submitted to EDS for payment.

Phone: (208) 287-1155 or (800) 362-7648
FAX: (800) 359-2236 or (208) 334-5242

3.9.6.1 Non-emergency Ambulance Transportation

If non-emergency transport by ambulance is medically necessary, Medicaid Ambulance Review issues a PA number.

Hospital-based ambulances must include the PA number in field 63 of the UB92 form and bill on an outpatient claim and in the appropriate field on the electronic form. Run sheets are not required when the claim is submitted to EDS.

3.9.6.2 Emergency Transportation

FAX or mail notice of emergency and non-emergency transports to Medicaid Ambulance Review at:

FAX (208) 334-5242 or (800) 359-2236

Division of Medicaid
Medicaid Ambulance Review
P.O. Box 83720
Boise, ID 83720-0036

3.9.7 Requests for Retrospective Review/Authorization

To obtain a retrospective authorization for emergency services and/or transportation, fax or mail a copy of the completed claim form and patient care record to Medicaid Ambulance Review. Attach a copy of the third party EOB if applicable.

Upon receipt of the completed claim information:

- The appropriateness of the revenue code billed is evaluated and may be downgraded to a non-emergency service.
- The claim is evaluated for appropriate treatment and disposable supply codes as requested. All requested supplies and treatment must be medically appropriate for the medical condition supported by the patient care record.
- Any potential denial or downgrade of the requested service is referred to an on-call emergency medicine physician for review prior to the denial or downgrade.

An approved or denied decision is submitted to EDS and a *Notice of Decision* is generated to the client and the ambulance provider. The *Notice of Decision* will include any PA numbers, procedure codes, dates of service, and number of units necessary for billing. Questions regarding *Notice of Decision* should be directed to Medicaid Ambulance Review.

Contact Medicaid Ambulance Review at:

(208) 287-1155 (Boise calling area)
(800) 362-7648 (toll free)

3.9.7.1 Submitting Requests for Retrospective Review/Authorization

Phone: (208) 287-1155 or (800) 362-7648

FAX: (208) 334-5242 or (800) 359-2236

Division of Medicaid
Medicaid Ambulance Review
P.O. Box 83720
Boise, ID 83720-0036

3.9.8 Requests For Reconsideration (Appeals)

Providers may appeal a PA decision made by *Medicaid Ambulance Review* by following these steps:

Step 1 Carefully examine the *Notice of Decision for Medical Benefits* to ensure that the service(s) and requested procedure code was actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider determines that an inappropriate denial of service has occurred, the next step is to submit a written *Request for Reconsideration*.

Step 2 Prepare a written *Request for Reconsideration*, which includes any **additional** or extenuating circumstances and **specific** information that will assist the authorizing agent in the reconsideration review.

Step 3 Submit the written request directly to Medicaid Ambulance Review within 28 days of the date on the *Notice of Decision for Medical Benefits*.

Mail the *Request for Reconsideration* to:
Division of Medicaid
Medicaid Ambulance Review
P.O. Box 83720
Boise, ID 83720-0036

Step 4 Medicaid Ambulance Review will return a second *Notice of Decision for Medical Benefits* to the requestor within 30 days of receipt of the provider's *Request for Reconsideration*. If the **reconsidered** decision is still contested by the provider, the provider may then submit a written request for an appeal of the reconsideration review decision directly to the Department of Health and Welfare.

3.9.9 Requests For Reconsideration (Appeals) of Medicaid Ambulance Review

To submit a written request for an appeal of the *Medicaid Ambulance Review* decision, follow the steps below. Providers may fax all documentation but the fax must be followed with copies of original documents in the mail.

Step 1 Prepare a written request for an appeal that includes:

- a copy of the Notice of Decision for Medical Benefits from Medicaid Ambulance Review
- a copy of the Request for Reconsideration from the provider

- a copy of the second Notice of Decision for Medical Benefits from Medicaid Ambulance Review showing that the request for reconsideration was performed
- an explanation of why the reconsideration remains contested by the provider
- copies of all supporting documentation

Step 2 Mail the information to:

Hearings Coordinator
Idaho Department of Health & Welfare
Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036

3.10 Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. These outpatient services are limited to clients and providers who meet the criteria specifically identified in the *Rules Governing the Medical Assistance Program* (IDAPA 16.03.09.128.). Providers must operate an American Diabetes Association (ADA) Recognized Diabetes Education Program to provide group diabetes counseling/training. Only Certified Diabetes Educators (CDE) may provide individual counseling through a recognized program in a physician's office or outpatient hospital. Their counseling services must be billed under the provider number of their employer, i.e., the hospital or physician's clinic provider number.

3.10.1 Individual Counseling-Diabetes/Education Training

For reimbursement, bill with procedure code **G0108** (in one-hour increments), in conjunction with Revenue Code **942** to comply with Medicare billing instructions. The CDE's services are to augment and not be substituted for the services a physician is expected to provide to diabetic clients. Medicaid allows only twelve (12) hours per client every five (5) years for individual counseling.

3.10.2 Group Counseling-Diabetes Education/Training

For reimbursement, bill with procedure code **G0109** (one-hour increments), in conjunction with Revenue Code **942** to comply with Medicare billing instructions. Only hospitals operating an ADA Recognized Program may bill for group counseling. Medicaid allows only twenty-four (24) hours per client every five (5) years for group counseling.

3.11 Dietitian Service Policy

3.11.1 Overview

Dieticians may bill the Medicaid program directly for nutritional services provided to pregnant women and children. Nutritional services include intensive nutritional education, counseling, and monitoring. Either a registered dietician must render these services **or** an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. If a dietician works for a hospital, the hospital bills Medicaid directly for the services.

3.11.2 Covered Services

3.11.2.1 Pregnant Women Services (PW)

Nutritional services for women enrolled in the PW program. All listed criteria must be met:

- Must be ordered by the patient's physician, nurse practitioner, or nurse midwife.
- Must be delivered after confirmation of pregnancy.

Extend only through the 60th day after delivery.

3.11.2.2 Early and Periodic Screening, Diagnosis, and Treatment Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services benefit are for children through the month of their twenty-first (21st) birthday. All criteria listed must be met:

- must be discovered by an EPSDT screen
- ordered by a physician
- determined to be medically necessary
- determined to not be due to obesity

3.11.3 Limitations

Note: If a dietitian works for a hospital, then the hospital bills directly for this service.

3.11.3.1 PW

Payment for two (2) visits during the calendar year is available at a rate established under the provisions of IDAPA 16.03.09.060.04. If a dietitian works for a hospital, then the hospital bills directly for this service.

3.11.3.2 EPSDT

Payment for two (2) visits during the calendar year is available at a rate established under the provisions of IDAPA 16.03.09.060.04.

Children may receive two (2) additional visits when prior authorized by the EPSDT Coordinator. Mail prior authorization request to the following address:

Idaho Medicaid
Bureau of Medical Care
Attn: EPSDT Coordinator
P.O. Box 83720
Boise, Idaho 83720-0036

3.11.4 Procedure Codes

Service	Code	Modifier	Description
PW Nutritional Services	S9470	**U5**	Nutritional Counseling, dietician visit *The **U5** (PW) modifier is required when reporting dietician services for the PW Program*
EPSDT Nutritional Services	S9470	No modifier required	Nutritional Counseling, dietician visit

3.12 Claim Billing

3.12.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

- To submit electronic claims, use the HIPAA-compliant 837 transaction.
- To submit claims on paper, use original red UB-92 claim forms available from local form suppliers.

All claims must be received within one year of the date of service.

See **Section 2** for more information on electronic billing.

3.12.2 Electronic Claims

For PES software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.12.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

Surgical procedure codes
Idaho Medicaid allows **25** surgical procedure codes on an electronic HIPAA 837 Institutional claim.

Four modifiers
On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding HCPCS or CPT code, up to 4 modifiers are allowed. (On a paper claim, only 2 modifiers are accepted.)

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

Type of bill (TOB) codes
Idaho Medicaid rejects all electronic transactions with TOB codes ending in a value of 6. Electronic HIPAA 837 claims with valid TOB codes not covered by Idaho Medicaid are rejected before processing.

Condition codes
Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional claim.

Value, occurrence, and occurrence span codes
Idaho Medicaid allows **24** value, **24** occurrence, and **24** occurrence span codes on the electronic HIPAA 837 Institutional claim.

Diagnosis codes
Idaho Medicaid allows **27** diagnosis codes on the electronic HIPAA 837 Institutional claim.

Ambulance services
Idaho requires the following information when submitting an electronic HIPAA 837 Institutional claim for ambulance services.

- Transport Code
- Transport Reason Code
- Transport Distance
- Condition Code
- Round Trip Purpose when the transport code is equal to X for round trip.

National Drug Code (NDC) information with HCPCS and CPT codes
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Institutional services.

3.12.3 Guidelines for Paper Claim Forms

3.12.3.1 How to Complete the Paper Claim Form

The following will speed claim processing:

See **Section 3.12.3.4**, for instructions on completing specific fields.

- Complete all required areas of the UB92 claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning.
- Keep claim form clean. Use correction tape to cover errors.
- A maximum of 23 line items per claim can be accepted. If the number of services performed exceeds 23 lines, prepare a new claim form and complete the required data elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Be sure to sign the form in field 85. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.12.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.12.3.3 Completing Specific Fields on a Paper Claim Form

Refer to 3.13.3.5, Sample Claim Form, to see a sample UB-92 claim with all fields numbered. Provider questions regarding hospice policy and coverage requirements are referred to the *Rules Governing the Medical Assistance Program*.

The following numbered items correspond to the UB-92 claim form. Consult the 'Use' column to determine if information in any particular field is required and refer to the 'Description' column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Unlabeled field	Required	Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA). **Note:** If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.
4	TYPE OF BILL	Required	Type of Bill: Enter the three-digit code from the UB92 manual. Adjustment type-of-bill codes are not appropriate for Idaho Medicaid billings. See **Section 3.1.7** for Type of Bill codes.
6 **A & B**	STATEMENT COVERS PERIOD	Required	Statement Covers Period From/Through: The beginning and ending service dates of the period included on the bill. **Administratively Necessary (AND):** The from date is the month, day, and year the client was discharged from inpatient acute level of care. **Outpatient Claims**: Outpatient claims must indicate the specific dates in **Field 45** to eliminate duplicate appearing services. **Late or Additional Charges:** **Inpatient** claims - see field 42 for information. **Outpatient** claims - see field 45 for information. **Accommodation Charges:** Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospital room occupancy when a client is discharged under normal circumstances. Although there is no reimbursement for the discharge day, that date should always be entered on the claim form. This ensures that the hospital receives reimbursement for the last full day of accommodation. **Extended Hospitalization:** If a client requires extended hospitalization and the hospital decides to send an interim claim, enter patient status code **30** in **Field 22**. This code tells the system that the client is still a patient and to reimburse the hospital for the last day on the claim. ***Example:*** Claims for three sequential interim bills would have the following sequential date and patient status format: **Patient Days** **Claim / From / To Date / Status / Billed** 1 / 01/15-01/31/04 / 30 / 17 2 / 02/01-02/15/04 / 30 / 15 3 / 02/16-02/24/04 / 01 / 8 **Note:** If patient status 30 is not used, the accommodation rate formula will not balance and the system will deny the claim.

Field	Field Name	Use	Description
7	COV D	Required	Covered Days: Required for inpatient claims only
12	PATIENT NAME	Required	Patient Name: Enter the client's name exactly as it is spelled on the client's Medicaid ID card. Be sure to enter the last name first, followed by the first name and middle initial.
19	ADMISSION TYPE	Required Inpatient	Admission Type: Use the priority admission codes in the UB92 manual. Only codes 1, 2, 3, and 4 are allowed by Medicaid. **Required** for inpatient claims
20	ADMISSION SRC.	Required Inpatient	Admission Source: Use the one-digit source of admission codes 1 through 8 in the UB92 manual. Medicaid does not accept code 9. **Required** for inpatient claims **Not Required** for outpatient claims
21	D HR.	Required Inpatient	Discharge Hour: Enter the two-digit hour the client was discharged in military time. **Examples:** Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. **Required** for inpatient claims **Desired** for outpatient claims
22	STAT	Required Inpatient	Patient Status: Use one of the codes listed in **Section 3.1.9, Patient Status Codes**, to indicate patient status. **Required** for inpatient claims **Not Required** for outpatient claims
23	MEDICAL RECORD NO.	Desired	Medical/Health Record Number: The number assigned to the client's medical/health record.
39-41	VALUE CODES / AMOUNTS	Required: AN Days	Value Codes and Amounts: See **Section 3.5.4**, Billing Procedures, for directions on how to bill administratively necessary days (AND).
42	REV. CD.	Required Inpatient	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. Use revenue code 001 for a total line and enter the claim's total in field 47. **Inpatient claims (late, additional, or denied charges):** 1. Late or additional charges where the revenue code was **not** on the original claim: bill on a new claim for only the late or additional charges with the accommodation rate and revenue code**.** Note in the Field 84, *"Billing for late charges."* 2. Late or additional charges where the revenue code was paid on the original claim: submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: bill the denied line with the accommodation rate and revenue code on a new claim. Note in the Field 84, *"Billing for denied lines."* **Outpatient claims (late, additional, or denied charges):** For instructions for outpatients billing refer to Field 45.
44	HCPCS/RATES	Required If Applicable	CPT/HCPCS/MODIFIERS/RATES: All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with **CPT** or HCPCS notation in **Section 3.5.5 Revenue Codes** and **Section 3.7.3 Ancillary Revenue Codes**. If the code requires a modifier, put one space between the code and modifier. For example, PET scans require a HCPCS code and the TC modifier (i.e. G0222 TC).

Field	Field Name	Use	Description
45	SERV. DATE	Required Outpatient	Service Dates: Required for all outpatient services. Enter the specific date of service for all charges or the claims will be denied. **Outpatient claims (late, additional, or denied charges):** 1. Late or additional charges **outside** the date span in Field 6: bill on a new claim form. Note in the Field 84, *"Billing for late charges."* 2. Late or additional charges **within** the date span in Field 6 with the **same** revenue codes and the **same** specific date: submit on an adjustment request form. 3. Late or additional charges **within** the date span in Field 6 with **different** revenue codes: bill on a new claim form. Note in the Field 84, *"Billing for late charges."* 4. Resubmit all denied charges on a new claim.
46	SERV. UNITS	Required	Units of Service: Enter the total number of covered accommodation days or ancillary units of service. Units of service for accommodations must correlate accurately to the service rendered. ***Example:*** Accommodation Code = Number of days the level of service was rendered. **Note:** It is important to put the most appropriate rate next to the related code. Do not average charges for the same code. If a client in the hospital receives three different levels of care, each must be billed on a separate line. ***Example:*** Level I = $100 x 3 units of service Level II = $150 x 2 units of service Level III = $200 x 1 unit of service
47	TOTAL CHARGES	Required	Total charges: Bill total covered charges only. Ancillary Charges Formula: Revenue Code Fee X Units of Service Total Charges Accommodation Rate Formula: Daily Rate X Units of Service Total Charges
In Fields 50 through 62, each field has three lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one other payer in addition to Medicaid, enter all primary payer date on line A and all Medicaid data on line B. If there are two other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer date on line B, and all Medicaid data on line C.			
50 A	PAYER	Not required	Payer A: **If** Medicaid is the only payer, enter "Idaho Medicaid" in Field 50A. **If** there is one other payer in addition to Medicaid, enter the name of the group or plan in **field 50A** and enter *"Idaho Medicaid"* in **Field 50B**.
50 B	PAYER	Not required	Payer B: If there are two other payers in addition to Medicaid, enter the names of the group or plan in **Fields 50A** and **50B** and enter *"Idaho Medicaid"* in **Field 50C**.
50 C	PAYER	Not required	Payer C: If there are two other payers in addition to Medicaid, enter *"Idaho Medicaid"* in **Field 50C**.

Field	Field Name	Use	Description
51 A-C	PROVIDER NO.	Required	Provider number: Enter the nine-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in 50 A-C. ***Example:*** in Field 50A, Medicare is entered as the Payer. In Field 51A, enter the identification number used by Medicare for the provider. ***Example:*** in Field 50B, Healthy Home Insurance Company is entered as the Payer. In Field 51B enter the identification number used by Healthy Home Insurance Company for the provider.
54	PRIOR PAYMENTS	Required If Applicable	Prior Payments — Payers and Client: **Required** if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do **not** include previous Medicaid payments.
55	EST. AMOUNT DUE	Not required	Estimated Amount Due: Total charges due (total from **Field 47**) minus prior payments (total from **Field 54**).
58	INSURED'S NAME	Desired	Insured's Name: If the client's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the client's Medicaid ID card. Be sure to enter the last name first, followed by the first name and middle initial.
59	P. REL	Desired	Patient's Relationship to Insured: See the UB-92 Manual for the two-digit relationship codes.
60	CERT.-SSN-HIC. ID NO,	Required	Client Identification Number: Enter the seven-digit MID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a 0 (zero) in the eighth through the eleventh positions. ***Example:*** 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).
61	GROUP NAME	Not required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	INSURANCE GROUP NO.	Not required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORI-ZATION CODES	Required If Applicable	Treatment Authorization Codes: prior authorization (PA) number for administratively necessary days or retrospective reviews or PA number for ambulance run by EMS.
67	PRIN. DIAG. CD.	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. Do **not** use "E" diagnosis codes.
68-75	OTHER DIAG. CODES	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. Do **not** use "E" diagnosis codes.
76	ADM. DIAG. CD.	Required	Admitting Diagnosis Code: **Required** for inpatient **Desired** for outpatient claims Peer Review Organization (PRO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the Qualis Provider Manual.

Field	Field Name	Use	Description
77	E-CODE	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the CMS 1500 claim form for professional claims.)
80	PRINCIPAL PROCEDURE CODE / DATE	Desired	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical or obstetrical procedure. Procedure date is required if procedure code is used.
81 A-E	OTHER PROCEDURE CODE / DATE	Desired	Other Procedure Codes and Dates: Enter all secondary surgical or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
82	ATTENDING PHYS. ID	Required	Attending Physician Identification Number: **Inpatient** — Enter the Idaho Medicaid Provider number for the physician attending the patient. This is the physician primarily responsible for the care of the client from the beginning of this hospitalization. **Outpatient** — Enter the Idaho Medicaid Provider number for the physician referring the client to the hospital.
83A-B	OTHER PHYS. ID	Required Healthy Connection	Other Physician Identification Number: **Required** for Healthy Connections clients referred to the hospital by the primary care provider. Enter the primary care provider's 9-digit numerical referral number in field 83A. Do not include the letters "HC" before the number.
84	REMARKS	Not required	Remarks: Enter information when applicable. For clients who have only Medicare Part A, enter *"Client has Part A only."* Other information to be entered may include: timely proof, ICN, retro-eligibility, or no Third Party Coverage.
85	PROVIDER RE-PRESENTATIVE	Required	Provider Representative Signature: Signature of the hospital's authorized agent or signature on record. The claim will be returned if it is not signed.
86	DATE	Required	Date Bill Submitted

3.12.3.4 Sample Paper Claim Form